State of California-Health and Human Services Agency

Department of Health Services

Medical Services Claim Form
FY 20____ – 20____

Emergency Medical Services Appropriation (EMSA) Contract Back Program

Ind./Group MediCal Number

1. Attending Physician (Last Name, First name)

2. Group/Provider Name

3. EMSA Provider Enrollment No.

Patient Information

4. Patient Last Name

5. Patient First Name

6. Patient Social Security Number

7. Patient Date of Birth

8. Sex (M/F)

9. Address

10. City

11. State

12. Zip Code

Patient Demographic Information

13. Number in Household

14. Family Gross Monthly Income

15. Family Source of Income

16. Type of Employment

17. Ethnicity

Family Gross Monthly Income Table

1	$	0-499
2	$	500-999
3	$	1,000-1,499
4	$	1,500-1,999
5	$	2,000-2,499
6	$	2,500-2,999
7	$	3,000-3,499
8	$	3,500-3,999
9	$	4,000 +

Source of Income Table

1 None
2 Earned through employment
3 Disability or Worker's Compensation
4 Retirement
5 General or Public Assistance
6 Other (i.e., V.A. benefits, interest, dividends, rent, child support, etc.)
7 Unknown

Type of Employment Table

1 Executive, administrative, managerial, professional, technical, and related support
2 Production, inspection, repair, craft, handlers, helpers, laborers, and transportation
3 Sales, service
4 Farming, forestry, fishing
5 Unemployed
6 Unknown

Ethnicity Table

1 White
2 Black
3 Hispanic
4 Native American/Eskimo/ Aleutian
5 Asian/Pacific Islander
6 Other
7 Unknown

Place Patient Was Seen

18. Name of Facility (Hospital/Clinic/MD office)

19. Facility Number

20. City

21. Zip Code

22. County No.

23. Service Setting

Service Setting

1 Hospital Emergency Room (Emergency Services)
2 Hospital Outpatient Department
3 Free Standing Clinic or Health Center
4 Physician's Office
5 Hospital Inpatient Department
6 Other/Unknown

Mail EMSA Contract Back Program claims to:

Department of Health Services
Office of County Health Services
Emergency Medical Services Appropriation Program
1501 Capitol Avenue, Suite 71-5195
P.O. Box 997413
Sacramento, CA 95899-7413
Attn: Marlene Carrillo

EMSA USE ONLY

24. Document Control Number (DCN)

(Continued on reverse.)

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EMSA Contract Back Program

Treatment Services Information

25. Category of Service	26. Diagnosis Code	27. Date of Service
	.	

1Emergency (EMSA)
2 Obstetric
3 Pediatric

(Use ICD 9 CM, if service setting is inpatient use Discharge Diagnosis)

Inpatient Data

28. Admission Date	29. Discharge Date

Outpatient/Emergency Room/Clinic/Physician's Office Date
(Complete if Service Setting is 1, 2, 3 or 4)

30. Type of Outpatient Service	31. Emergency Room Disposition

Type of Outpatient Service

1 Primary Care
2 Specialty Care
3 Home Health Care
4 Dental Care
5 Laboratory
6 Medical Supplies
7 Optometry
8 Pharmacy
9 Podiatry
10 Detoxification
11 Radiology
12 Ambulatory Surgery
13 Other/Unknown

Emergency Room Disposition

1 Non-emergency: released
2 Emergency: released
3 Non-emergency: transferred to another hospital
4 Emergency: transferred to another hospital
5 Non-emergency: admitted to hospital
6 Emergency: admitted to hospital
7 Deceased

Treatment Services

	Procedure Description	Date of Service	Emergency Service (Y/N)	Procedure Code	Quantity	Charges
1	32.	33.	34.	35.	36.	37.
2	38.	39.	40.	41.	42.	43.
3	44.	45.	46.	47.	48.	49.
4	50.	51.	52.	53.	54.	55.

(Please note: Any and all additional charges beyond these four entries need to be submitted on a separate claim form.)

56. Total Claim Amount	$

Affidavit of Physician or Physician's Representative

By submitting and signing this claim form, I, as the attending physician or authorized certified representative, hereby certify that on the third billing attempt, a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Program has been provided to the patient named on this claim as required by theEMSA Contract Back Program. I also certify that the information contained on this EMSA Contract Back Program claim form is true, accurate, and complete, and that the physician/physician group has read, understands and agrees to be bound by and comply with the policies, conditions and statements contained in the EMSA Policies and Procedures Manual, related statutes and regulations, and the Annual EMSA Contract Back Program's Physician Enrollment and Claim Certification form. I further certify and agree to cease all current and future collection efforts when any level of reimbursement of this claim is received from the EMSA Contract Back Program.

_____ Date

_____ Signature (Authorized Representative Only)